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ABSTRACT

To further supplement the larger conference proceedings held by the Society for Health and Human Values, a smaller Southwest Regional Institute was held in October of 1973. Conference participants examined the rationale for including human values as an area of study in health professional education, the process by which this kind of teaching can be accomplished successfully, and the context in which human values programs can develop optimally. Presentations are included from five small discussion groups, each led by a consultant who had been selected for his acknowledged expertise. The first centers on the role of medical history in the education of the humanist physician, offering some suggestions on how medical history should be taught. The second centers on why philosphy should be a part of health professional education. The third defines religious studies in the context of health professional education. The fourth examines law and medicine, the myths and realities in the medical school classroom. The author points out that everything a doctor does in the field of medicine is related in some manner to the legal system, and doctors should become more aware of those aspects. The fifth centers around the role of social psychology, medical behavioral sciences, and health professional education. The first and second proceedings are described in SO 007 920 and SO 007 921. (Author/JR)

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Institute on Human Values in Medicine

SOUTHWEST REGIONAL INSTITUTE

Society for Health and Human Values
and
University of Texas Medical Branch
Galveston, Texas

October 17-19, 1973

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SOUTHWEST REGIONAL INSTITUTE
ON HUMAN VALUES IN MEDICINE

Galveston, Texas

October 18-19, 1973

Co-Sponsors:

University of Texas Medical Branch
Institute on Human Values in Medicine

Introduction

The 1971 and 1972 sessions of the Institute on Human Values in Medicine were national conferences attended by humanists and medical educators who explored together ways in which human values could be studied in a meaningful, disciplined, relevant way as part of education in the health professions.

Participants in these two meetings represented schools of liberal arts and schools of medicine, allied health, and nursing from many parts of the United States; but many other schools were not able to send representatives in either 1971 or 1972. Although a variety of reasons prevented their participation, an especially common obstacle was geography: the east-coast location of both sessions made it difficult for many interested individuals to attend.

A welcome opportunity to alter this situation arose for the Institute when the University of Texas Medical Branch at Galveston offered to host and co-sponsor the Southwest Regional Institute on Human Values in Medicine in October, 1973. This proposal was made by Joseph M. White, M.D., then Dean of the School of Medicine, and Chester R. Burns, M.D., Ph.D., then Director of the History of Medicine Division.*

*Recently the History of Medicine Division became part of UTMB's new Institute for the Medical Humanities.

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Although financial support for this meeting came from both the Institute on Human Values in Medicine and UTMB, the burden of organizing and executing the conference was borne almost entirely by UTMB, especially by Chester Burns and his colleagues and staff. No one who participated in the Southwest Regional Institute needs to be told how extremely well things went; but for those who were not present, data are available in support of compliments and commendations. Evaluation forms completed by participants at the close of the meeting attest to the thorough success of this conference in attaining its objectives.* Dr. Chester Burns deserves particular credit for this, a fact which I would like to acknowledge here on behalf of the Institute on Human Values in Medicine. On my own behalf, I wish to express my personal thanks to him for taking over a myriad of chores that otherwise would have fallen to me.

Objectives

The Southwest Regional Institute on Human Values in Medicine was designed to examine in small discussion groups the rationale for including human values as an area of study in health professional education; the process by which this kind of teaching can be accomplished successfully; and the context in which human values programs can develop optimally. This pattern of discussion had yielded good results during the second session of the Institute on Human Values in Medicine (April, 1972 - Williamsburg, Virginia). Therefore it was adopted with only slight modifications for the 1973 meeting at UTMB.

*A copy of the evaluation form is included at the end of this report.

Format

Five small discussion groups were organized; each consisted of eight to ten persons. In almost every instance, individual preferences for a particular group could be accommodated. Each group was led by a consultant who had been selected for his acknowledged expertise in one of the five areas delineated for discussion:

(A) History, History of Medicine, and Health Professional Education

Consultant: Guenter B. Risse, Ph.D.
Associate Professor and Chairman
Department of the History of Medicine
Center for the Health Sciences
University of Wisconsin

(B) Philosophy, Philosophy of Medicine, and Health Professional Education

Consultant: K. Danner Clouser, Ph.D.
Professor of Philosophy
Department of Humanities
Milton S. Hershey Medical Center
Pennsylvania State University

(C) Theology, Religion and Medicine, and Health Professional Education

Consultant: Ruel W. Tyson, Jr., B.D.
Professor of Religion
Department of Religion
University of North Carolina at Chapel Hill

(D) Law, Medical Jurisprudence, and Health Professional Education

Consultant: George J. Annas, J.D., M.P.H.
Director, Center for Law and Health Sciences
Boston University School of Law

(E) Social Psychology, Medical Behavioral Sciences, and Health Professional Education

Consultant: Samuel A. Banks, Ph.D.
Associate Professor of Medicine and Religion
Department of Community Health and Family Medicine
College of Medicine
University of Florida

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Discussion in the small groups focused on these three questions:

From the disciplines identified, what should be taught in health professional education?

Why should that body of knowledge and set of skills be taught to health professional students?

How can effective teaching programs be developed?

The outcomes of these small-group meetings are presented separately in the remainder of this report. (Please see table of contents for their location.)

Participants

Fifty persons participated in the two-day meeting. Their names, addresses, and institutional affiliations are appended to this report; please see pages 61-63.

Invitations to attend were sent to the medical schools in Louisiana, Arkansas, Oklahoma, New Mexico, and Arizona; the medical schools at Baylor and Texas Tech; each of the ten health professional schools in the University of Texas System; and various arts and sciences schools, graduate schools, and other professional schools in the southwest. Each institution was invited to select one faculty member and one student for participation in the Southwest Regional Institute.

Lorraine L. Hunt, Ph.D.
Project Director and Editor
Institute on Human Values in Medicine

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The five small groups described on pages 3 and 4 were designated by the letters A, B, C, D, and E. In addition, the individuals in each group were assigned numbers: 1, 2, 3, 4, etc.

These dual identifications were devised for logistical purposes so that discussion could occur in an organized way across groups as well as within groups.

No one foresaw that Bill Knisely would muse on this and then be visited by his muse.

"The Inclination"

or, E-4, and More

Who am I - and why?
Am I an "A," a "B," or a "C"?
Am I also a "1" or a "2" or a "3"?!
Oh, woe is me!
Or, woe am I!
    Hello, there!
You are who?!
Well - How do you do?
What do you do all day through?
Oh! - So!
    Let's See!
Why do we sigh?
Where do we lie?
When do we die?
How do we know?
What will we sow?
Or, when will we go?
    The person-patient
What is the object? the goal
You say is the soul!
In what ways do our cures care?
Can we change ourselves, do we dare?
Can we <u>de</u>cline our <u>in</u>clines
                in our clinics today?
A Motley Crew like me and you?

William H. Knisely, Ph.D.
Assistant to the Chancellor
for Health Affairs
University of Texas System

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Group A: History, History of Medicine, and Health Professional Education

Consultant: Guenter B. Risse, M.D., Ph.D.

Editor's Note

The intention of reviewing audio-tapes in order to summarize the discussion of "History, History of Medicine, and Health Professional Education" was thwarted by a defective tape recorder that failed to record any of Group A's sessions. By the time the recording problem was discovered, it was clearly impossible for anyone to recollect dependably significant details of what was said in the group. Consequently the following essay by Dr. Risse, commissioned by the Institute on Human Values in Medicine, does not claim to be a report of the group discussion.

Drawing upon his expertise as a professional medical historian and his experience as a medical doctor and a teacher of medical students, Dr. Risse offers his own answers to the questions that were the focus of his group's discussion:

Why should medical history be taught in medical school?

What medical history should be taught?

How should medical history be taught?

Who should teach medical history?

A detailed description of one of Dr. Risse's own courses in medical history is included in his essay.

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THE ROLE OF MEDICAL HISTORY IN THE EDUCATION OF THE "HUMANIST" PHYSICIAN: A RE-EVALUATION

Guenter B. Risse, M.D., Ph.D.
Associate Professor and Chairman
Department of the History of Medicine
Center for the Health Sciences
University of Wisconsin
Madison, Wisconsin 53706

I

INTRODUCTION

> "Reduced to the elements of science and technique, medicine is in danger of losing its human quality, of becoming dangerously impersonal .... Neither science nor technique can give physicians an adequate or whole view of the human person."[1]
>
> Paul Tournier

In recent years, both students and educators have often perceived medical education as a dehumanizing process stressing the scientific aspects of disease.[2] Such a realization has prompted an attempt to consciously reintroduce the humanities into the study of medicine, especially in the area of human values.[3]

As a result of concerted efforts in this direction, the Society for Health and Human Values was formed in April, 1969, by a group of clinicians, administrators, humanists, and social scientists active in medical education. Two national sessions of an Institute on Human Values in Medicine, organized by the Society, were held in 1971 and 1972, dealing extensively with the rationale, process, and context in which such values could be taught in the medical curriculum.[4]

During these two meetings the role of certain humanistic disciplines (especially philosophy and literature) in medicine was discussed. Subsequently the individual role of five fields of knowledge - history, philosophy, law, religion, and social psychology - became the focus of a regional workshop held in 1973 at the University of Texas Medical Branch, Galveston.

Discussing the importance of relevant context in which to teach the humanities to medical students, one of the participants in the first Institute complained about the lack of success of medical history. He attributed the failure to an antiquarian approach in which anecdotal triviality and tedious enumerations of accomplishments appeared disconnected from contemporary medicine, thus generating apathy among the students.[5]

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Although this was the only specific reference to medical history made at those meetings, the charge that medical history is taught as a steady out-pouring of dates and names is not novel. Viewed in context, it is ironic for the historian of medicine to witness the increasing interaction of other humanistic disciplines with medicine, while his own--which can certainly claim squatter's rights over the new arrivals--seems to be fading in importance and is often branded as "irrelevant."[6] Paradoxically, this decline bears no relationship to the flourishing state of the discipline as a specialized field of historical study.

Physicians have been interested in and often teach a plainly descriptive history of medicine's highlights, which are carefully placed as successive steps of a progressive stairway of scientific achievements leading up to our contemporary summit. Such a stress on a Whig interpretation of history[7] measures and judges every development in the evolution of modern medicine by the extent of its contribution to the present. Its simplistic naivete and distorting "presentism" relies heavily on the dates and names that form a continuous chain of successive events lifted out of their social, economic, and cultural contexts.

Moreover, the individual historical figures are divided into praiseworthy ones who were "right" from our present vantage point, and others who were "wrong," reaching dead-end paths or formulating erroneous conclusions; in a word, there are "winners" and "losers" in this game of historical one-upmanship.

While such a historical approach seems to lead to apathy and disinterest on the part of medical students, the health professional views both anecdotal and "Whig" medical history as having an important inspirational value. The discipline, by portraying the cumulative intellectual inheritance of medicine, is said to contribute significantly to the process of professionalization. Other considerations frequently expressed refer to the imponderable aesthetic feelings generated when physicians and medical students peruse the historical literature related to their profession during hours of leisure and relaxation. Since a large portion of medical historical teaching is still being done by health science practitioners - active or emeritus - it is not surprising to witness periodic complaints of antiquarianism and irrelevancy.

The professional historians of medicine, on the other hand, constitute a small minority in the ranks of those who teach the subject. Their research interests are generally narrow, dealing with the health sciences in a given historical period, a particular country, stressing the social or intellectural aspects of healing,etc. They attempt to use their expertise to reconstruct in depth the proper frameworks, social and cultural, in which medical thinking and practice took place.

Most of them are interested in discussing conceptual problems which arise from a study of the medical past, topics which often may have little meaning to the non-historian. I submit, therefore, that an alienation exists between physicians and professional historians, which centers upon their divergent views about what medical history should be taught, and the educational goals to be achieved.[8] This estrangement is a result of the gradual professionalization which has occurred in the field of medical history.

Faced with budgetary restraints and time limitations, medical educators have tended to eliminate from the curriculum those subjects not seen as directly "relevant" or useful to the training of health professionals. While medical history is widely recognized as a valid academic and intellectual pursuit, its role in the education of today's health professional is going through a rather agonizing process of re-assessment. There is agreement that the fledgling physician is not going to increase his technical skills and proficiency by studying history. The accelerating obsolescence of scientific medical knowledge makes incursions into past developments often meaningless for future research, while the information explosion forces attention upon present developments. Classical disease descriptions have largely lost their relevance, modified in their original appearance, course, and complications by contemporary therapy. Modern technology has radically changed most older diagnostic skills, and the painstakingly acquired minutiae of physical diagnosis recorded in older books are no longer needed.

What follows is a highly personal attempt to sketch a "new" history of medicine which could make a lasting contribution to the education of our health professionals. The model has, at present, only been used specifically in the medical school for the education of its students, but has, I would argue, equal value in the training of other health professionals. Its focus is not history for its own sake, as a streamlined story of past events, but history as a tool to provide awareness of present conditions, act as a critique of contemporary problems, and perhaps, serve occasionally as a guide in the resolution of certain dilemmas.

Although history does not repeat itself--every new situation arises within a unique context--Santayana's dictum that those who ignore history are bound to repeat its errors is partially true. At the peril of sounding presumptuous, I would adhere to Arthur Schlesinger's "instrumentalist" view of history, and repeat that the knowledge of the past guarantees superior wisdom in making present and future choices.

Before defining <u>what</u> should be taught and <u>how</u> it should be taught, it would be more appropriate to discuss the rationale: <u>why</u> medical history should be taught, from the vantage point of a professional historian.

II

WHY SHOULD MEDICAL HISTORY BE TAUGHT IN MEDICAL SCHOOL?

> "One cannot really understand what medicine is facing today in this country and throughout the world without having some knowledge of the past.... The study of history helps us move forward intelligently. Those who are concerned about how American medicine will meet the challenges that have come with large governmental support, with the new concept that health is a basic right, cannot understand without some comprehension of how medicine arrived at where we are now.... Thinking of history as an antiquarian pastime only has beclouded the need for understanding its relevance in the sense under consideration."
>
> George P. Berry[9]

The above quotation reflects the reason for teaching medical history in the medical school: to develop a sense of historical perspective.

The term perspective denotes depth, overview, and the ability to evaluate data and events as to their comparative importance. As the pace of change accelerates in the last quarter of the 20th century, long-term human values have begun to lose meaning. The health sciences face mounting dilemmas brought about by the explosion of knowledge in science, and by our sophisticated uses of technology. Instead of merely a forward-looking attitude, which accepts the given present as an uncontrollable reality, the medical student is in need of an awareness of the past for his analysis and assessment of the present. In clinical medicine such an ability to organize and evaluate facts becomes essential for his success as a healer. In broader terms, the historical perspective furnishes awarenesses, perceptions, and knowledge useful for an understanding of medicine in general that can give direction and purpose to future physicians.

Such a perspective is most important in the following categories:

1. The scientific development of medicine. The medical past provides essential information about medicine as an art and as a science. Knowledge about the development of scientific underpinnings for the health sciences is just as important as historical information needed to interpret the content, methodology, and change of our scientific knowledge. The changing fortunes of medical ideas, discoveries, and practices reveal the transient character of knowledge, while illuminating recurrent patterns of thought. An understanding of the so-called "scientific method," its principles and pitfalls, uncovers past errors and the nature of the knowledge obtained. By pointing out the permanence of conflict, its ingredients and resolution, valuable insights can be gained

about the conceptual changes which have produced the present state of the art. Humility and scepticism can both be stimulated through an analysis of past attitudes and approaches. Both qualities can only enhance the powers of judgment of our students, in the laboratory as well as at the bedside.

2. The social character of medicine. An historical perspective of medicine readily uncovers the fact that healing is an integral component of society, and continuously interacts with other political, economic, and cultural forces that are operative in a given society. By pointing out the changing concepts of health and disease and examining how society and individuals have acted in the face of epidemics and famines, medical history sensitizes the student to the importance of social factors.

While the previously mentioned "Whig" history of medicine simplistically depicts medicine as an autonomous, goal-directed discipline in its own right, the submersion into a societal framework exposes influences and relationships which have and will continue to shape medicine in the future. Professional roles and images, delivery of health care, and patients' health beliefs and expectations can be grasped more easily with the help of historical examples. This should not be misconstrued as a course in medical sociology, but rather as an opportunity to emphasize the social dimensions of healing.

3. The ethical aspects of medicine. Finally, medical history is capable of providing a useful background to the understanding of ethical and moral issues in medicine. By portraying the close dependence of medical conduct upon the prevailing human values, history is able to help distinguish basic, unchanging principles from those attitudes inspired by specific needs and circumstances.

Working closely together with law, ethics, philosophy, and medical anthropology, history can provide the necessary framework in which these disciplines can examine medicine. It thus becomes another field of the "humanities" being introduced into medical education.

To summarize, then, I am proposing a "pragmatic" history of medicine that is not a clearly defined body of knowledge to be imparted to medical students, but rather an operational approach taking its cue from the dilemmas confronting medicine today. As such it is issue-oriented rather than chronological, with the present concerns as starting points for a retrospective historical analysis. The intent is to provide students with an external view of issues which are already affecting their professional lives, and will continue to do so.

III

WHAT MEDICAL HISTORY SHOULD BE TAUGHT?

From the preceding rationale it follows, then, that there is no defined body of medical historical knowledge which should be taught to medical students. Our limited objective is to provide a perspective for medical events, a way of looking at things which is historical. Under those circumstances, the actual content is merely dictated by contemporary perceptions of issues that deeply influence the theory and practice of medicine in this country, and should therefore be of interest to the medical students.

The stress is on attitudinal change, not the mastery of a given content or acquisition of a certain skill. This fact allows flexibility in planning such an issue-oriented course, and the periodic substitution of topics which in the course of current events lose some of their importance. Lest one suppose that such a format represents an actual "sell-out" to students' preferences for "relevancy," the instructor's judicious selection of subjects is actually based on their suitability for historical analysis and fruitful discussion. On the other hand, there has been considerable medical student input into the formulation of the present curriculum.

What follows is an exposition of the course now being taught to freshman medical students in the second semester at the University of Wisconsin - Madison, entitled HISTORICAL PERSPECTIVES IN MEDICINE. The fifteen discussion topics are listed below together with the instructional objectives established for each subject. Each theme is discussed during two 50-minute seminars scheduled every week throughout the semester.

1. Introduction to medical history

Objectives:

1.1) Knowledge of humanistic studies in contemporary medical curricula - their value for the future physician.

1.2) Appreciation of the role that medical history can play in medical education - the value of an historical perspective.

1.3) Analysis and definition of what constitutes a "humane" physician - affective and cognitive components.

1.4) The interaction between history, ethics, law, philosophy, sociology, and anthropology on medical issues.

2. Medicine in contemporary primitive societies

Objectives:

2.1) Basic understanding of magico-religious healing - the nature of shamanism.

2.2) Awareness of the confrontation between magico-religious and Western scientific medicine.

2.3) Knowledge of recent efforts to breach the schism between Western and primitive medicine practiced by the American Indians.

2.4) Sensitivity concerning the transcultural gaps when dealing with the health care of ethnic minorities. The role of folk medicine and the importance of so-called "irregular" practitioners.

3. Western medical traditions

Objectives:

3.1) Recognition concerning the origins of "Western" healing in ancient Greece.

3.2) Perception of the shift from supranatural to empirico-rational explanations and activities in medicine.

3.3) The changing social status of the physician: priest, craftsman, entrepreneur, state employee.

4. Professional values in medicine

Objectives:

4.1) Itinerant Greek physicians: the need for self-regulation through oaths. The role of religious and moral beliefs.

4.2) Medical oaths and etiquette: their reflection of societal values and the changing nature of medical practice.

4.3) Nazi human experimentation: new awareness concerning the etchical aspects of experimental intervention.

4.4) Knowledge concerning the development of medical ethics in the U.S.

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5. Faith healing and Christianity

Objectives:

5.1) Knowledge of temple curing in ancient Greece and church cures following the advent of Christianity.

5.2) Understanding of Christian Science healing.

5.3) Sensitivity to the contemporary role of religious healing.

6. Basic sciences in medicine

Objectives:

6.1) Perception of the crucial role played by human anatomy in the development of "Western" medical knowledge.

6.2) Realization that the decisive characteristic of "Western" medicine is its basic science underpinnings: anatomy, physiology, pathology, microbiology, biochemistry, pharmacology, etc.

6.3) Awareness of the crucial conceptual changes responsible for the rise of scientific medicine: body-mind division and the mechanical view of the organism.

7. The role of hospitals in medicine

Objectives:

7.1) Knowledge of the factors responsible for the rise of hospitals: urbanization, technological innovations, views and treatment of disease, etc.

7.2) The changing implications of hospitalization for patients, and its relationship to social class.

7.3) The gradual growth of hospital functions from custodial and assistential to curative and educational.

7.4) The influence of the hospital on the professional and social status of the physician, and the rise of medical specialization.

8. Public health and preventive medicine

Objectives:

8.1) Awareness of the historical roots of public health: the

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interplay of politics, medicine, and public policy under the dramatic impact of epidemics. How does a given society solve its most urgent health problems?

8.2) Perception of the history, geography, and social impact of diseases as determinants of public health measures.

8.3) The implication of social class on public health. Analysis of the factors responsible for reform in public health.

8.4) Preventive vs. curative medicine: status and economics. The concept of health maintenance.

9. The physician-patient relationship

Objectives:

9.1) Analysis of the economic, professional, and personal interests of the healer: the instinct to help the sick.

9.2) Awareness of the social and scientific factors affecting the relationship: institutions, technology, epidemics, expansion of medical knowledge, socio-economic barriers, domestic medicine, etc.

9.3) The patient as an object of medical study: the problem of depersonalization. "Western" medicine's disease orientation and organ-function analysis. Where is the whole man?

9.4) Women as medical practitioners and patients: stereotyped images and role-playing.

10. Health care: rights and responsibilities

Objectives:

10.1) Historical analysis of the right-to-health concept: individual or social responsibility? The idea of health insurance.

10.2) The impact of modern diagnostic therapeutic methods on health care.

10.3) Knowledge of the role played by churches, private charitable and public institutions in the provision of health care.

10.4) Aanalysis of the so-called "health industry" and its historical development. The role of patients in health services. Consumerism in medicine.

11. Health progress in the U.S.: 1900-1974

Objectives:

11.1) Knowledge regarding the measurement of health progress: mortality and morbidity charts, life expectation, etc.

11.2) Awareness of the selective nature of health progress: the fundamental shift in the epidemiology of disease from acute infections to chronic degenerative illnesses.

11.3) Understanding the dichotomy between scientific and social aspects of disease, and the implications for health progress: the example of V.D.

11.4) The importance of non-medical factors in the improvement of health conditions: nutrition, housing, hygiene, employment, etc.

12. Medical quackery

Objectives:

12.1) Definition of quackery and its primary characteristic: deliberate fraud. The position of the "irregular" practitioner and the deviant healing practices.

12.2) Analysis of why people have historically sought out quacks. The practice of self-medication.

12.3) Food and medicine. Half truths in nutritional science and food faddism.

12.4) Awareness of contemporary healing cults and their historical antecedents.

13. Medical education

Objectives:

13.1) The process of becoming a medical professional. Analysis of the educational procedure: basic science orientation, need for diagnostic skills, clinical problem solving. The Wisconsin Preceptor Program.

13.2) Understanding regarding the implementation and impact of the Flexner report after 1910 in American medical education. How do these changes affect the educational process today?

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13.3) Admission to medical school: does the process foster intellectual and socio-economic elitism? The historical development of screening tests.

13.4) The needs of medical manpower. The role of the foreign medical graduate. Is the American model of medical education useful in developing countries?

14. Traditional medical systems in India and China

Objectives:

14.1) Knowledge of traditional non-Western systems of healing still in use in both India and China. Explanation of the most important concepts of disease formation and removal.

14.2) Perception of the contemporary efforts being made to integrate these systems with modern scientific medicine. Analysis of the conceptual and practical difficulties surrounding such an amalgamation.

14.3) Political, socio-economic, and cultural factors operative in the survival of traditional medical systems. The contrasting health scene in India and China.

15. Non-Western medical practices

Objectives:

15.1) Knowledge regarding the use of Chinese acupuncture and native herbs in contemporary medical practice. Discussion of their historical antecedents.

15.2) Awareness of the difficulties in explaining and evaluating scientifically these seemingly successful techniques. Present clinical and basic research in acupuncture.

15.3) Recognition of the socio-political and cultural milieu in which these medical procedures are practiced. The difficulties of transplanting these methods to the West. Awareness of their potential usefulness in modern medicine.

15.4) Critical attitude regarding widespread faddism and deception with these medical practices in the West.

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To actually illustrate how the previously described historical perspectives can be furnished through the established objectives, let us take, for example, topic no. 11, entitled Health Progress in the U.S.: 1900-1974. Analyzing objective 11.3, one can discuss with the students

a) the changing nature of scientific knowledge regarding venereal diseases - such as the diagnostic difficulties, the protracted and often ineffectual medical treatments, resistance to modern chemotherapy, etc.;

b) an historical perspective regarding the social aspects of venereal diseases as factors in the re-emergence of these ailments in epidemic proportions; and

c) an historical view of the ethical and moral aspects of venereal diseases, how these factors have influenced physician reporting, research plans (Tuskegee experiment), and medical treatment in general.

IV

HOW SHOULD MEDICAL HISTORY BE TAUGHT?

Before answering this question, it would be useful to expound briefly on the problem of who should teach a course such as the one outlined above.

As one would surmise, I personally can see only a professional medical historian assuming this function--that is to say, an individual whose training has given him or her the competence necessary to carry out an effective teaching program in this field.

Whether such a person needs to be a physician with historical training or someone who has a Ph.D. in history with some knowledge about medicine, has been extensively debated in recent years.[10] This issue, still controversial, will be avoided during this discussion. What is clear, however, is that such a competent teacher should preferably be devoted to the subject on a full-time basis in order to carefully prepare and conduct such an issue-oriented course. Whether the historian is a member of a basic or clinical department, or actually represents an independent unit of medical history will depend on the particular structural conditions of the medical school in which he or she has a faculty appointment. Strong institutional support is, obviously, an absolute necessity.

The first issue to be discussed in this section is whether the course outlined above should be a required or an elective item in the curriculum. A good argument could be made for insisting that all medical students be exposed to historical perspectives, especially those who do not have a good background in the humanities. Moreover, in strict terms of student perception, required courses carry a seal of legitimacy and necessity which forces the medical student to devote time and effort in order to assure promotion. If the historical perspective is, indeed, a valuable attitude for students to acquire, why should not everyone be confronted with it?

I would like to argue for an elective course instead. The present trends in American medical education indicate a strong tendency towards increasing elective time in school, thereby providing alternate choices and multiple pathways in the once monolithic curricular structure. Moreover, asking for elective time is far less threatening to other disciplines vying for a slice of the instructional pie, and avoids protracted battles in committees to enter and remain on the curriculum. Medical history needs all the friends it can possibly make!

The other question to be examined regarding this issue is that of motivation. How much effort should be devoted to medical students who have little interest in the humanities, and especially history? Would not the compulsory nature of such studies only generate resentment and perhaps open hostility?

Designing the course as an elective allows for student choice, and insures a well-motivated group of students who will take this instruction in addition to their required curriculum load. We presently have a ceiling enrollment of twenty-five students - close to 20% of the class - in order to maintain a manageable seminar-discussion format.

This brings up the next issue. One should avoid at all costs formal lecturing since, in my opinion, it stifles student enthusiasm and participation. Such a method fosters what I have called a "television mentality," which transfers the medical student into a passive auditor whose attention decreases progressively as the lecture unfolds from the lectern.

The more preferable instruction, as carried out in our medical school, is the establishment of an informal discussion group with the instructor as a guide and leader. Armed with a schedule, a list of discussion topics, and educational objectives, the student is encouraged to read a series of assigned readings (copies of articles are generally furnished prior to class) and to engage in free dialogue. A number of optional readings are available at the reserve desk of the medical library, together with some video-cassettes on specific topics.

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Each meeting begins with a brief introduction, furnished by the instructor, which may be underlined with the use of visual aids. In most cases, the discussion begins focusing on a concrete case or event of contemporary medical interest, and then, under the guidance of the teacher, moves back in time to allow for analysis and an examination of the issues scheduled for historical scrutiny.

The issue-oriented course does not allow the student to acquire a systematic knowledge of the history of medicine. Breadth has been sacrificed for depth. Each topic is discussed during two weekly sessions of 50 minutes, giving the course a total of 30 contact hours during the entire semester.

Since we are interested in acquainting students primarily with an historical perspective rather than content, our evaluation procedures do not involve examinations or quizzes. A student's class participation is the determining factor on whether he or she receives a pass or fail grade for such an elective course. Certain students may either volunteer for short presentations in class on topics of special interest to them, fitting into the outlined objectives, or write short essays on favorite subjects. All are given a final questionnaire that provides useful evaluation of course content as well as instructional techniques and materials. Such feedback allows for periodic improvements to make the course experience more meaningful to the students.

The material presented here represents a simple elective course on historical perspectives offered to incoming freshman medical students during their second semester. It merely constitutes an initial conceptual exposure to the past, providing frameworks of reference in which the students can place medicine, society, and human values with more precision and understanding. This first encounter by no means exhausts the introduction of history into medical education. During the last two clinical years, medical history can take its place alongside ethics, philosophy, sociology, anthropology, and law to provide depth and insights into health issues which also relate to these disciplines. Such an interplay can be exposed in clinical conferences and informal small group discussions, as well as in more formalized courses. In our department, a fair number of senior medical students select an 8-week elective reading course on specific issues in American medicine. The scenarios for such an interaction are, I am sure, almost limitless, and are not the subject of the present discussion.

A contemporary historian has warned us that total historical perspective is an optical illusion, and that as historians we must operate with partial knowledge, often biased, oversimplified, and suspect.[11] While our fragile generalizations may not exhibit scientific validity, we believe that a backward look can be helpful for those involved in contemporary medicine. As Jacques Barzun once said: "It is not what you can do with history, but what history does to you, that is its use."

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4. See Institute on Human Values in Medicine, proceedings of the first session, April 12-14, 1971, and second session, April 26-28, 1972. Philadelphia: Society for Health and Human Values, 1971 and 1972.

5. See summary of E. Fuller Torrey's remarks, Proceedings of the first session, Institute on Human Values in Medicine, 1971, pp. 91-92.

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7. The term was coined by the historian Herbert Butterfield in his book The Whig Interpretation of History, London: Bell, 1931. It refers to the tendencies exhibited by certain British constitutional historians to view their topics as a progressive broadening of human rights in a struggle between "good" liberals and "bad" conservatives.

8. The situation can be equated, in a sense, to the relationship between science teachers and historians of science. See S.G. Brush, "Should the history of science be rated X?" Science 183(1974), pp. 1164-1172.

9. See Education in the History of Medicine, ed. by J.B. Blake, New York: Hafner, 1968, pp. 36-37.

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11. Will and Ariel Durant, The Lessons of History, New York: Simon and Schuster, 1968, pp. 12-13.

Editor's Note

K. Danner Clouser has published a number of articles that address the same questions of rationale, process, and context that Group B considered in its discussion of "Philosophy, Philosophy of Medicine, and Health Professional Education."

One of Professor Clouser's major essays was included in material distributed to all participants as background reading in preparation for the Southwest Regional Institute: "Philosophy and Medicine: The Clinical Management of a Mixed Marriage," Proceedings of the First Session (April, 1971), Institute on Human Values in Medicine, 723 Witherspoon Building, Philadelphia, Pennsylvania 19107.

Other relevant articles by Professor Clouser are

"Humanities and the Medical School: A Sketched Rationale and Description," British Journal of Medical Education, 5, No. 3 (September, 1971), 226-231.

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Group B: Philosophy, Philosophy of Medicine, and Health Professional Education

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Summary of Group Discussions

Rationale: Why teach philosophy as part of health professional education?

Medicine has itself become philosophical, partly as a consequence of its rapid scientific and technological development. Having expanded enormously its capability to affect man in many ways, medicine now finds itself immersed in issues and activities that are value-laden, especially in regard to decision-making about human life. Medicine now affects, and is in turn affected by, many areas that formerly it had almost no contact with, such as law, politics, and economics.

These and other changes in the study and practice of the health professions require that health professionals understand their own disciplines conceptually, and that they be able to relate on a conceptual level to other disciplines, also. Philosophy can help one learn how to think conceptually, and then how to translate formulations into appropriate actions. Philosophy also helps one develop perspective, both personal and professional. This is an extremely important quality in a health professional, for he or she occupies a value-laden role on which our society has conferred great power.

To encourage physicians and other health professionals to become more "philosophical" is to encourage them to become more self-reflective and more conscious of the existence of choices and alternatives, and of the relation between options and values. It is desirable that health professionals be fully aware of what they are doing, and why; and also of what they are choosing not to do, and why. Informed, reflective decision-making based on maximum data--human as well as laboratory data--is more apt to lead to appropriate action that does not violate either human values or medical realities.

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Studies in philosophy help one develop broader awareness of the nature of values, and their ubiquity and consequences. For example, health care systems have their own philosophies based on values that are often unacknowledged and unexamined--yet these values impinge constantly upon both providers and consumers of the systems' services. Values also underlie physician-patient relationships--and, in quite a different vein, relationships between knowledge and action. How new knowledge (and the power implicit in it) is used, is determined by the values of the knowers--a sobering thought when one reflects upon technology's tendency to objectify people as well as things, eventually.

Process: How can this kind of teaching be accomplished successfully?

Specific approaches to this kind of teaching in health professional schools were suggested.

1. Offer courses, either required or elective. Make sure they are clearly related to the students' current experiences, either their academic work or their clinical assignments.

2. Arrange to participate from time to time in other courses in the curriculum whose material is appropriate for supplement from philosophy.

3. Conduct regular, continuous seminars for all interested persons--faculty, students, house-staff, others--who wish to pursue seriously a subject of common interest.

4. Offer tutorials for students who have special interests, and perhaps some background for independent study in philosophy acquired prior to their entry into health professional education.

5. Participate in appropriate clinical activities, such as CPCs, grand rounds, etc. (An important value of this is the opportunity it affords the humanist to learn about the realities of students' and clinicians' everyday experience.)

Some additional advice was offered, such as: begin with specific problems, and then move on to generalization and conceptualization. Emphasize small-group discussion--the lecture format is a poor choice for this kind of teaching. Finally, assign readings with care. Whenever possible, choose material that is in medical journals or other professional literature that the students regard as "relevant" to health professionals.

Context: What milieu is most conducive to the continuing development of philosophy teaching in health professional education?

Lack of time prevented the group from dealing extensively with this question. However, there was quick consensus on an initial observation that clear, demonstrated institutional support for philosophy in the curriculum is essential. Infiltration ("slipping in through the back door") is an ill-advised method of entry that eventually generates serious problems of acceptance and continuation. Administrative and faculty backing should be overt, and both groups should actually participate in some aspect of the philosophy program if at all possible If the students' other teachers are already persuaded that philosophical studies are valuable and relevant, presuading the students is much easier.

It is helpful if everyone involved in the enterprise can acknowledge at the outset that interdisciplinary endeavors take exceptional amounts of time, effort, and patience. There is no short-cut to developing a common language free of jargon (philosophical, medical, scientific, or any other kind), and a mutual openness to someone else's point of view. Negotiation over critical issues--curriculum time, for instance--proceeds much more constructively if the negotiating parties understand each other as professionals and trust each other as persons.

Group C: Theology, Religion and Medicine, and Health Professional Education

Consultant: Ruel W. Tyson, Jr., B.D.

Editor's Note

The audio-tapes of the discussion of "Theology, Religion and Medicine, and Health Professional Education" indicate rather clearly that the members of this group found it difficult to keep separate three different points of view that intersected repeatedly within their topic area: that of the theologian; that of the "practical theologian," or clergyman/priest/minister; and that of the "religionist," or professional humanist whose field is religious studies.

Without clear definitions of these disciplines, it became difficult to identify the contributions that each field can make to health professional education, and the role that professional persons in each of these fields can play in the medical setting--in regard to health care as well as health education.

Feeling that it would be valuable to provide clarification of these fundamental points, the Institute on Human Values in Medicine commissioned Professor Ruel Tyson to prepare a paper dealing principally with issues of definition. It is presented here in lieu of a summary of the group discussion led by him. This alternative form of a report on that group seems proper in view of the large amount of time spent by the group members in seeking definitions, especially definitions of roles.

Professor Tyson writes at length about the field of religious studies first, because it is his own field; and second, because it is a new discipline in the humanities. He focuses on religious studies without prejudice to past, present, and future contributions by theology and theologians.

A DEFINITION OF RELIGIOUS STUDIES

IN THE CONTEXT OF

HEALTH PROFESSIONAL EDUCATION

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Several distinctions are in order before addressing the central topic of this essay. The topic can be formulated as a question: What are the contributions of religious studies to the education of teachers and students in the health professions? Before going directly to this complex question, I wish to offer some definitions, which are suggestive rather than definitive, of theology, or theologians, and practical theology, or official representatives of a particular religion. Following these brief statements I wish to define religious studies before saying what this field of study can offer educators and students in health affairs.

Theology is the intellectual articulation of the sacred as perceived and embodied in the religious experience, stories, cultic action, and histories of a particular group. Traditionally, theology has been subsidiary to cultus; in the practice of religion priority has been given to cultic action, sacred story, and authorized teachings.

One of the earliest appearances of the word theology occurs in the second book of Plato's Republic. There it means "stories of the gods," but already the meaning of the term theology was changing so that its work was understood to be explanation and criticism of sacred stories. Cultic officials tend to focus on sacred stories as they have been received and enacted in the cultic actions and teachings. The theologian, as Max Weber has pointed out, was one of the first bearers of rationalism. So the habitual concern of the theologian is with "right" or "proper" stories told of the gods, sometimes as an apologist, often as a critic of a religious tradition, occasionally as an apostate from a cultic group. The cardinal point here is that the term theology is most appropriately prefaced by an adjective of religious identification: Christian, Jewish, Protestant, Roman Catholic, Lutheran, etc. Most theologians, whether confessionally or indirectly, serve or subserve a particular religious tradition, group, cult, or a confluence of several allied traditions.

It is true that today theology has become more ecumenical; still it is rare for the term to be used without reference to religious group or traditions, though for apologetical purposes some theologians underplay their cultic identifications. In so far as a theological inquiry bears some relation, explicit or covert, to a sacred story and its accompanying traditions and practices, it is impossible for it to become autonomous, or be theology in general. When this movement occurs theology has become speculative philosophy without benefit or hindrance of cultic story. It is therefore easy to understand why there has been an enduring tension between theological inquiry, which tends towards universal considerations, and the custodians of the cultus, those officials of the religious institutions whose work is the practical translation of religion and its value orientations in the form of ministerial work with a laity. This latest observation leads to the second definition I wish to make.

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Official practitioners of a particular religious tradition are variously called priests, teachers, pastors, ministers and chaplains (to kings, armies, and hospitals, for example). These persons, who may be either cultic officials or members of the laity, may be titled 'practical theologians' since they mediate religious guidance in the form of teaching, preaching, counseling, and liturgical action. They translate cultic doctrine and value to the problematics of practice in a particular locality and for a particular constitency. Persons occupying these roles are more concerned with therapy than with theory, though this does not mean that they are less educated or less appreciative of the theoretical dimensions of religious belief and practice than their sometimes colleague, the theologian. Practical theologians direct their attention to the nurture and practice of the religious life in a variety of contexts. They too may find themselves in a variety of tensions with the theologian whose intellectual vocation tends to direct his attention beyond the immediacies of practice, the authority of the cultic stories, and sacred traditions that endorse the work of religious guidance.

There is no doubt that each of these two groups has contributions to make to the education of students in the health professions at both professional and personal levels. Indeed there is a respectable record of their achievements, not the least of which is the founding of the Society for Health and Human Values. However, my attention in this essay is directed toward prospective contributions teachers and scholars in the relatively new field of religious studies can make to the work of professional schools in the health sciences.

Students in religious studies learn to read religious actions past and present. Religious action and thought, and their embodiments, are studied as a part and expression of human action and thought in a variety of cultural, spatial, and temporal locations. Such actions may be located in the history of one religious group; the student wants to learn how a religious group articulates its history, what principles and idioms it employs in doing so, or what historiography is embedded in the ways a community remembers its past.

Religious action may be located in a cultic liturgy, a text, a set of laws, a temple, or other kinds of monuments. Consequently, the student of these embodiments must learn about them through the frameworks of aesthetics, archaeology, anthropology, and the methods of textual analysis. The scholar of religions wants to understand the relation between cultic officials and the religious intellectuals, who may be theologians, and how both groups are related to the social structures as well as to philosophical and rhetorical schools resident in a society's cultural traditions. Not least in importance, the student of religious action wants to understand the laity of a particular religion--how the ethos sanctioned and vivified by cultic institutions and the world views they celebrate are worked into the sexual, family, political,

economic, and cultural life of lay members. The student can learn as much about the impact of Catholic Christianity in thirteenth-century Italy from biographies of monks, princes, sea captains, artists, diplomats, Jews, and Mohammedans as he can from the treatises and commentaries of well-known theologians.

In each set of data the student is seeking to discover how the world is delivered to the believer through the affective, symbolical, intellectual, and procedural forms of a particular religion. Frequently, he finds himself trying to discover how the yeast of religion blends into the bread of everyday life without benefit of appropriate culinary arts. Religious studies, employing the methods of historical, linguistic, anthropological, rhetorical, and philosophical disciplines, attempts to interpret religious action in a variety of contexts on both macro and micro scales. This is difficult at best since each religion, or a central feature of a religion, is itself an interpretation of man in nature, history, and society. This is not only the case when the focus of study is a religious text or a liturgy; it is equally so when the ordinary religious life of a member of a laity is the subject of study. The layman's use of religion in his personal, family, political, and professional life is one of the ways he interprets both his religion and his experience in these adjoining domains. The practical ethos of an ordinary religious person carries the implicit and rudimentary interpretation of nature, history, society, and the gods that a theological text presents more systematically and abstractly. The data about a religion may be drawn from both these sources, and each is of great value to the comprehensive understanding of a religion.

Religious studies focuses on the highly literate expressions in the poetry and prose of a religion; it is also attentive to the tacit interpretations of experience present in the ordinary ethos of less religiously literate folk whose occupations and concerns are other than religious and intellectual. Much that is called history of religions is in fact mainly the history of the monuments constructed by religious intellectuals like priests and theologians, and hence read only by subsequent intellectuals.

There are salutary if faint signs that scholarly attention is beginning to notice the importance of religion in the lives of a diversity of folk. Religion in the round of everyday life is beginning to be seen as one strand in the biographical narrative of persons living out of a variety of such narrative linkages. How do people build and have built into their lives the images, notions, promises and prescriptions offered by religious systems? In contemporary society, or in some important segments of contemporary society, the term "religious system" may be misleading. There may be, for example, lawyers, doctors, or military officers who have formal ties to religious organizations, yet whose sources of meaning and fundamental identities are derived, not from ostensible religious institutions, but from their occupational worlds.

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For some the guild, not the cult, may be the center through which the sacred is mediated.

The ethos and procedures of a profession may be more determinative of a person's orientation to primordial life issues and questions of value than a world view sponsored and evoked by a cult or religious institution. Of course, the problem of the sources of meaning in a highly differentiated society and how these multiple sources of meaning or orientation are woven into the life patterns of persons cannot be neatly distinguished. But that does not lessen the import of the issue: What gives a person, who may not be particularly self-conscious about primordial issues and unlikely to be preoccupied with them except in life crises, a sense of the togetherness of things, a working if tacit definition of order/disorder, good/bad, significant/insignificant, authority/obedience, beauty/ugliness? Why do I seem to say in my doings that this goes with that rather than some other thing?

Henry James wrote in the preface to Roderick Hudson: "Really, universally, relations stop nowhere, and the exquisite problem of the artist is eternally to draw, by a geometry of his own, the circle in which they shall happily appear to do so." But all of us have to become artists, and we all live among fellow artists, living and dead, personal and collective, as we try to work our geometries on what the novelist's brother William James called "the still wider rest of experience." Some things must fall together with other things or we fall apart. I am suggesting that occupation as much as cult or family provides some persons social metaphors within which they negotiate their various geometries. The study of religion in the common life of such persons pays attention to the form-giving, direction-setting, value-nurturing powers of their occupational form of life as well as to the formal affiliations such persons may have to religious organizations.

While we do not stake any exclusive claims to this difficult terrain of inquiry, students in religious studies are studying the ways men address and are addressed by the universe in cultic and non-cultic settings. Men do not always ascend to the tops of peaks to carry out their religious business; such transactions go on in offices, clinics, sidewalks, and particularly where decisions of great consequences are made, where events of transition--from birth to death--occur, and in regimes where persons are shaping themselves for an occupational identity. The student of religious actions does not pre-determine where his texts for study are to be found; they may be an ancient manuscript or tablet; and they may be living texts in the form of life lived in buildings that once were called temples and now are called hospitals. The student of religious actions does not restrict his definition of religious actors to those persons formally occupying roles as priests, theologians, or laity in cultic organizations. On the contrary, he may find actors, who were once in other locales called magicians, sorcerers, witch doctors, seers, or suppliants, performing actions the student of religion will

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want to argue are religious in their rituals and rationale, if not in their rhetoric. This is not especially surprising. Questions of proximate and final meanings typically emerge in those ecologies where primordial experiences of birth, suffering, death, allocation of scarce resources, and the necessity for difficult decisions occur in response to such life crises. Law courts and hospital corridors are the ordinary scenes of such actions.

Students working in this discipline have no interest in calling everything that might hold significance for human beings "religious," and, unlike some apologetical theologians, they have absolutely no interest in revealing the theological import of everything from "Peanuts" to Marilyn Monroe. The student of religious action undertakes tasks that are primarily analytical, descriptive, and comparative. He wants to isolate, if he can, religious action as a part, not a whole, of human action; but in order to do this, he tries not to abstract religious action from life patterns of human beings. If one wishes to describe, for example, the moral and religious life of a character in George Eliot's Middlemarch, this task of description cannot be achieved by isolating something called moral/religious action from the relationships of the characters to each other, the language they speak, the imaginations they have of each other--in short, the plot in their lives and the plot composed by the intersection of their lives, not to mention the hospitality and resistance with which the universe greets their ambitions and aspirations.

The student of religious studies, in addition to his usual concern with the formation and history of various religions in their public and organized configurations, is equally interested in the professional formation of those persons whose eventual professional identities will place them in daily proximity to decisive life experiences. Case studies in professional formation, whether the subjects are doctors, lawyers, or cultic officials, can teach the scholar how meanings are built into people's lives, how sensitivities to value issues are tuned, and which metaphors, clichés, and precedents are employed in response to fundamental life issues.

The analogy between life in a profession and similar processes at work in the religious context has not gone unnoticed by students of organizations and occupations. Referring to guilds in the middle ages from which many of our contemporary occupations derive, Emile Durkheim wrote: "What, then, were its main functions? In the first place, the guild was a religious collegium. Each had its own particular deity, its own ritual which, when the means were available, was celebrated in a specially dedicated temple. In the same way each family had their lar familiaris, each city its genius publicus, each collegium had its tutelary god or genius collegii."[1] It is not entirely surprising that Durkheim traced the origins of modern occupations to their guild origins in a book called Professional Ethics and Civic Morals.

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Alluding to features in contemporary organizations analogous to processes long studied and practiced by religious organizations, Robert Merton writes: ". . . there may ensue, in particular vocations and in particular types of organizations, the process of sanctification . . . . /Italics in the original./ This is to say that through sentiment-formation, emotional dependence upon bureaucratic symbols and status, and affective involvement in spheres of competence and authority, there develop prerogatives involving attitudes of moral legitimacy which are established as values in their own right, and are no longer viewed as merely technical means for expediting administration. One may note a tendency for certain bureaucratic norms, originally introduced for technical reasons, to become rigidified and sacred, although, as Durkheim would say, they are laique en apparence."[2]

The student of religious studies has a two-fold interest in professional formation, hence in the education of health professionals, or in what Merton called the process of sanctification. First, he has a pedagogical interest, to which I will return briefly. Second, he has a professional or scholarly interest. For he believes he can learn a great deal about the ways meaning is built into people's lives by studying the formation of professional lives of nurses, physicians, and allied health personnel; and his pedagogical role is predicated upon his scholarly commitments to this form of inquiry.

The extended rites of initiation into a profession or guild can teach much about how organizations nurture in their members a habitus and ethos which surrounds the technical performance of their tasks, a process that is informed by a world view, which in the case of a cult is enacted by the cultic liturgies and catechetical procedures, and in the case of a profession endorsed by its lore, rituals, and systems of deference observed in the performance of its work. For each a view of the world is dramatized and described that underwrites the forms of behavior that are prescribed for their members. As Kenneth Burks has observed, "occupations engender pre-occupations." Both religion as a cult and work as a profession generate a sense of what goes with what and how and why this is so. As Burke says, both depend upon a piety, which he defines as "the sense of what properly goes with what." He goes on to note that "this notion of piety is a response which extends through all the texture of our lives but has been concealed from us because we think we are so thoroughly without religion and think that the "pious process" is confined to the sphere of churchliness."[3]

The framework which has informed the preceding discussion has been summarized by reference to two terms widely used in anthropological literature, an increasingly rich source for the work of religious studies. The evaluative and aesthetic aspects of a given culture, or sub-culture like the culture of a profession, have been called by anthropologists "ethos";

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and the cognitive aspects, a "world view." Clifford Geertz shows how these two aspects of a culture interact upon each other:

> A people's ethos is the tone, character, and quality of their life, its moral and aesthetic style and mood; it is the underlying attitude toward themselves and their world that life reflects. Their world view is their picture of the way things in sheer actuality are, their concept of nature, of self, of society. It contains their most comprehensive ideas of order. Religious belief and ritual confront and mutually confirm one another; the ethos is made intellectually reasonable by being shown to represent a way of life implied by the actual state of affairs which the world view describes, and the world view is made emotionally acceptable by being presented as an image of an actual state of affairs of which such a way of life is an authentic expression.[4]

I will not soon forget a closing remark made by Edmund D. Pellegrino at the first meeting of the Institute on Human Values in Medicine at Arden House, some three or four years ago. With his deft sense for going to the center of any issue never more finely at work, he said, "Medicine is a powerful culture." It is a way of life, to use Geertz's phrase from the previous quotation, that encompasses a much wider domain than physicians; indeed, it exercises sovereignty over all health professions and beyond. Since Pellegrino first made that statement, I have been attempting to understand some of the forces that lend such compelling persuasion to his remark, and I would now claim the culture of medicine has maintained its integration and consequent power because it keeps in mutual confirmation its world view and ethos, effected through its rituals of initiation and procedures of practice.

Because of the formal similarity between the culture of religious groups and the culture of a profession like medicine, the student of religion is equipped, along with other colleagues in the humanities and social sciences, to assist educators in health professions in examining the material processes that the particular sub-culture we call medicine employs in the preparation of its students. But this rests on an arguable assumption, namely, that educators in health affairs intend to make the examination of a profession a strong ingredient in the preparation for the profession. This assumption may require that schools in the health professions be hospitable to "strangers" in their midst who speak a different language of analysis, diagnosis, and prescription. There is a demonstrable discovery that a student learns a great deal explicitly about the grammar and syntax of his own language, knowledge that he possessed only tacitly before, when he begins to learn a language that is strange to him.

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In these remarks I have alluded to but have not given a statement about what a student of religious studies might teach within the setting of schools of medicine, nursing, etc. This is not an oversight, since the issue I wanted to raise is a more fundamental one. It can be formulated as follows: Teaching students, along with colleagues in health affairs, can only be a serious and long-term venture if such teaching is predicated upon field research in the locales where the teaching is to occur. This view implies a rejection of the "service model" of the relation between disciplines in the humanities and health affairs, a model that endorses the occasional or steady offering of instruction by representatives of the humanities to students in health affairs. I have no difficulty with this policy if that teaching arises out of sustained inquiry by scholars in the humanities into those forms of life--the rhetorical, evaluative, philosophical--that inform the ethos and world view of the medical culture. For the scholarly investigator what is to be taught has to be engendered out of what he has learned. To be sure, he brings with him questions, hypotheses, methods, curiosity, but he should not bring with him pre-packaged units abstracted from the inner sanctums of his own discipline. He also comes (if he is invited to do so, for he has other solicitations as well) looking for colleagues in the schools of health affairs to join him in mutual inquiry, surely a convivial and epistemological prerequisite to the joint work of teaching. The situation which this Institute presents us is parallel to a similar situation described by an anthropologist and a literary critic.

> . . . the conviction continues to grow among leading figures in the Humanities and the Social Sciences that, as the cliché goes, "they have something to offer one another." The problem is how to effect the offering, reasonably unburnt.
>
> It is our assumption that this will best be done not by general, programmatic considerations of how the humanities, or some corner of them, are "related" to one another, or even of what over-all presuppositions they share in common, nor again of their supposedly complimentary or contradictory roles in the functioning of modern culture. Rather, it will be done, if it is done at all, when some of the more creative people in specific disciplines discover that they are in fact working from their contrasting methods, on quite similar problems or ranges of problems.
>
> It is when two (or more) scholars realize that, for all the differences between them, they are attacking highly similar issues, trying to solve closely related puzzles, that communication between them begins to look like a practical policy rather than an academic piety. Specific commonalities of intellectual interest make scholarly interchange possible and useful; and the creation of

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such interchange demands, and indeed consists in, the discovery and exploitations of such commonalities.[5]

I endorse this practical policy and reject the "academic piety."

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FOOTNOTES

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3. Kenneth Burke, Permanence and Change: An Anatomy of Purpose. Los Altos: Hermes Publications, 1954, pp. 74-75.

4. Clifford Geertz, The Interpretation of Culture. New York: Basic Books, 1973, pp. 126-27.

5. Clifford Geertz and Paul de Man, "Preface to the Issue 'Myth, Symbol, and Culture,'" Daedalus, Winter, 1973, p. vi.

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Group D: Law, Medical Jurisprudence, and Health Professional Education

Consultant: George J. Annas, J.D., M.P.H.

Editor's Note

The problem of defective tape recorders described on page 6 afflicted also the group that met to discuss "Law, Medical Jurisprudence, and Health Professional Education."

Fortunately the consultant and leader for this group, George J. Annas, was willing to accept the commission of the Institute on Human Values in Medicine to prepare the following essay as a substitute for a report of the group's meetings. It is not meant to represent the group members' actual discussion, since that obviously could not be retrieved accurately enough. Instead Mr. Annas offers his own expert views on the questions his group explored:

Why is legal medicine important in the medical school curriculum?

What goals should the legal medicine course have?

What should be taught?

Mr. Annas also presents an outline by subject matter of a legal medicine course designed for the final year of the medical school curriculum.

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LAW AND MEDICINE:

MYTHS AND REALITIES IN THE MEDICAL SCHOOL CLASSROOM

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The goal of legal education in a nutshell is to get the student to "think like a lawyer." As the law professor in the movie "The Paper Chase" put it to his first-year class, "You come in here with a skull full of mush, and you leave thinking like a lawyer." The goal of legal medicine courses in medical schools, on the other hand, has often seemed to be to get the medical student thinking bad things about lawyers. While the total answer to the legendary distrust between these two professions may not be in an understanding of methodology, this brief paper will suggest that one way to increase cooperation between the professions is to teach legal medicine in medical schools in a way that emphasizes methods of approaching problems, and seeks to dispel the major myths that doctors have about the law.

The different methods of problem-solving employed by the two professions have been oversimplified in many ways. One lawyer has made the following illustration, although it is as misleading as it is instructive:

> "If a doctor were called upon to treat typhoid fever he would probably try to find out what kind of water the patient drank, and clean out the well so that no one else would get typhoid from the same source. But if a lawyer were called on to treat a typhoid patient he would give him thirty days in jail, and then he would think that nobody else would ever dare to drink the impure water . . . lawyers think that there is only one way to make men good, and that is to put them in such terror that they do not dare to be bad."

This illustration is taken seriously by many. Thus, many current legal medicine courses in medical schools are seemingly designed to follow this "legal model" by putting the medical student in "terror" of being sued for malpractice, and to instruct him to regard lawyers as wicked adversaries. As Professor William J. Curran of Harvard University has noted, when medical jurisprudence is badly taught (and this is probably the rule rather than the exception), the students come away with three messages:

1. Lawyers are out to get you if you don't watch out.

2. Law is very, very dull.

3. If you do show an interest in legal medicine, you must be a little strange.

Legal medicine is thus faced with a problem that is unique to the humanities. There have traditionally been and continue to be courses in forensic medicine or medical jurisprudence in a majority of the medical schools in this country. The problem is therefore not to justify the place of law in the curriculum. But this only adds another difficulty. Because legal medicine courses have been taught poorly in the past, with an overemphasis on malpractice and criminology, justification for continuing to teach legal medicine requires not only that old negative feelings be removed, but also a redefinition of what is meant by the term "legal medicine" to encompass issues relevant to today's doctor. The challenge, in short, is to carefully define what should be taught in such a course, and how it should be taught. Lest one not be convinced that such a course is essential to medical education, however, it is useful to begin with a discussion of why such a course is important.

WHY IS LEGAL MEDICINE IMPORTANT IN THE MEDICAL SCHOOL CURRICULUM?

Almost everything the doctor does in the practice of medicine is in some manner regulated by the legal system. The law defines what the doctor can or cannot do in terms of medical practice, and the geographic bounds of his authority. It defines his relationship with his patient in terms of contract and implied contract, and it defines his duty to his patients in terms of obtaining both consent and informed consent. The law governs what drugs a doctor may prescribe and in what quantities. It defines the rights of patients, and prescribes remedies for patients who are injured by doctors. The list is easily broadened to include staff privileges and duties, human experimentation regulations, privacy, confidentiality, privileged communications, abortion, sterilization, euthanasia, consultation, abandonment, referral, admission to hospital, emergency room duties, discharge from hospital, Medicare, Medicaid, private health insurance plans, comprehensive health planning, "certificate of need," licensing, physician's assistants, anatomical gifts, autopsy, etc. Wherever a doctor turns he is confronted by law--statutory, case, and constitutional--that governs or limits his conduct in one way or another.

When the doctor does not understand the law and the obligations and limitations it puts on his practice, the doctor is at an extreme disadvantage. He may, for example, not tell his patient about all of the serious potential side-effects of a surgical treatment, and find himself being sued for failure to obtain informed consent. He may improperly use a restricted drug and find his license to use such drugs revoked. He may disclose information learned in confidence to a spouse, relative, or friends, and find himself being sued for breach of confidence. He may refuse to treat a teenage girl who has been raped because he does not understand the law of consent regarding minors. He

may put a terminally ill patient on a respirator against the patient's will because he mistakenly believes that the law requires him to take all steps in his power to preserve the man's life. As with the previous list, this one is almost endless. Two further examples, however, deserve more extensive comment.

When physicians see a person injured on the side of the road or elsewhere outside of their office or hospital, they are often reluctant to stop and render aid. This is said to be because they have been taught to fear lawsuits and believe that if they try to help, they may be opening themselves up for a malpractice suit. This in turn led the A.M.A., together with local medical societies, to get so-called "Good Samaritan" statutes passed which protect physicians from suit for ordinary negligence in such a situation. The fact is, however, that no one has even been able to document a case where a physician in this country has ever had to pay any money damages to anyone suing him for stopping and rendering aid (and allegedly aggravating the condition). Moreover, one survey of 40,000 physicians found that fewer than 10 had any difficulties at all arising out of this type of situation, and none of these ended in any formal legal action. The reason that almost no lawsuits on this subject have been filed is rather easy to discern if one thinks the matter through. It is extremely difficult for a jury to vote to penalize a doctor for doing what most of us want all doctors to do: stop and render what aid they can in an emergency. One state (Vermont) has even passed a statute making it a crime not to stop and render aid. While there are other reasons doctors don't stop (e.g., like the rest of us, they may simply not want to "get involved"; or they may not know anything about emergency medicine), it is probably fair to say that a misunderstanding of the law by the vast majority of doctors has led to much unnecessary suffering, and has probably directly contributed to a number of unnecessary deaths.

Another example is provided by the controversy surrounding the withholding of heroic treatment from infants with certain types of defects. Two doctors at Yale-New Haven Hospital, for example, reported in the fall of 1973 that this practice had been going on with the consent of the parents of the children at that institution's pediatric intensive care unit since 1971. Over 40 infants had died after treatment efforts were terminated. The doctors concluded their account by saying: "If working out these dilemmas in ways such as those we suggest is in violation of the law, we believe the law should be changed." When questioned later, one of the authors revealed a profound misunderstanding of the function of law when he replied that they had purposely not asked a lawyer for his opinion as to the legality of their actions because they were afraid that the lawyer would tell them that what they had in mind was against the law! Somehow he seemed to believe that disobeying the law was all right so long as you were not personally informed of the law by an attorney prior to the time of your actions. This same logic would make speeding permissible so long as the driver did not look at any of the speed limit signs on the highway.

I trust the point is made. Law is such a pervasive force in the practice of medicine that to proceed without some basic understanding of its design, purposes, and limits can place both the doctor and his patients in unnecessary peril.

WHAT GOALS SHOULD THE LEGAL MEDICINE COURSE HAVE?

While many potential goals could be listed, perhaps the most important and fundamental are:

1. To develop an accurate picture of the role of the attorney in society.

2. To impart some basic legal concepts, enough so that the student knows when to consult an attorney.

3. To impart a basic understanding of the legal model of decision-making.

WHAT SHOULD BE TAUGHT?

It is ironic, but perhaps the most important subject matter to be taught is medical malpractice. The approach, however, must be completely different from the "scare them to death" tactics of the past. Specifically, the prevailing myths about malpractice should be exposed and replaced by a careful examination of the "real" problems with the current system of compensation for doctor-induced medical injury. For example, it is simply not true that most malpractice actions are "nuisance suits" and utterly without merit. Almost all surveys show that the majority of them have merit, and even malpractice insurers estimate more than 45% to be fully justified. Nor does the contingency fee system (an arrangement whereby the attorney gets about 30% of the total award) spawn unjustified suits. On the contrary, since 30% of nothing is nothing, the attorney actually screens meritless claims. Attorneys, for example, take only 1 in every 8 malpractice suits that clients bring them. Nor is there any hard data supporting the claim that malpractice suits are inducing many physicians to practice positive defensive medicine by prescribing too many tests. Indeed, all independent studies show that doctors usually give too few rather than too many diagnostic tests. The list of malpractice myths could go on.

The more important fact about malpractice litigation is that only one claim is asserted for every 226,000 doctor-patient contacts. This means that the average physician will get sued only once every 69 years - and explains why most doctors never have a malpractice action brought against them during their entire careers. The major problems with the

present system are not that it is unfair to doctors, but that many injured patients never get compensated, and those who do must pay high legal fees and wait for years to receive their money. What type of compensation scheme should be built into national health insurance, and what new types of quality control mechanisms should be developed, are issues that young doctors should be thinking about. Wasting time on deprecating "unfair legal rules" or the contingency fee system is both misguided and unproductive.*

The next important concept to teach is that of decision-making models. Law is an extremely formal system designed to make decisions in a way which is meant to insure that the interests of all affected parties are taken into account. The emphasis is on the process, specifically on "due process." When a lawyer looks at the doctor's method of decision-making, he is likely to be horrified at the following five "anti-due process" characteristics:

1. Ambiguous identification of the decision-maker.

2. Ambiguous identification of the person or entity that commands the decision-maker's loyalty.

3. Control of the pertinent medical information by the attending physician.

4. Lack of reporting or review of the ultimate treatment decision.

5. Frequent justification of the decision on the basis of public policy.**

Unlike the doctor treating a terminally ill patient with a close, demanding family, for example, the lawyer is likely to know exactly who his client is, who has the power to make the relevant decisions, access to all pertinent information, an opportunity to have the initial decision reviewed in the courts, and any appeal to public policy left in the hands of public officials, such as the courts or the legislature. A comparison of the two systems of decision-making should be enlightening

* The issue of the medical profession's attitude toward malpractice litigation is gone into in considerably more detail in G. J. Annas, "Malpractice: Are the Doctors Right?" Trial, (July/August, 1974).

**Specific examples of how these characteristics affect medical decisions are explored in G. J. Annas, "Medical Remedies and Human Rights," Human Rights, 2 (1972), 151-167.

for the student. The doctor, for example, is often taught that he must make the decision because he has the training and expertise to make it probable that his decision will be better than anyone else's. The lawyer, on the other hand, is taught to be an advocate for the cause of the client in a context where someone else will make the ultimate decision. His role is to present his client's case in the best possible light, knowing that his opponent will do the same for his client, and that through this exchange the judge or jury will be able to determine which party should prevail. He is not a scientist, but an advocate. If the law is against him, he'll argue the facts; and if the facts are against him, he'll argue the law. The point is not to identify some ultimate "truth," but to make a persuasive presentation of his client's position.

Finally, it is extremely important to begin to familiarize the medical student with the types of legal issues he will face in day-to-day medical practice. While corporate, tax, securities, real estate, and banking lawyers can probably get through their entire careers without knowing anything about medicine, no doctor can get through a day of active practice without facing, in knowledge or ignorance, significant legal issues. Perhaps the most fruitful way of discussing the types of issues that are likely to be of concern is to present an outline by subject-matter of a legal medicine course designed for the final year of the medical school curriculum. The course is divided by general subject matter, and the time allotments are suggested minimums.

Topic Outline: Legal Medicine

1. Sources of Law. Case law; statutes; regulations; hospital by-laws; medical ethics; relationship of law and morality; positive vs. natural law; organization of courts and legislative bodies; adversary procedure in litigation; medical and hospital records as evidence; privileged communication; role of the attorney. (2 hours)

2. Medical Licensure and Practice Regulation. Granting and revocation of licenses; licensure and registration of para-medical personnel; granting and revocation of staff privileges; control of narcotics and dangerous drugs; public health regulations; contagious diseases; V.D. control. (2 hours)

3. Compensation for Personal Injuries. Medical aspects of tort liability; negligent and intentional injuries; contributory and comparative negligence; measure of damages; statutory compensation under federal and state law; occupational disease laws; insurance coverage for compensation or liability; workmen's compensation; the use of medical records and reports; medical testimony and expert opinion; causation from the legal viewpoint. (2 hours)

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4. Medical Professional Liability. Tort law in medical practice; standards of medical care; liability for acts of employees; consent and informed consent; assault and battery; res ipsa loquitur; contract and warranty of cure; invasion of privacy, why patients sue; medical accident prevention; insurance; statute of limitations; medical evidence; alternatives to the present malpractice system (arbitration, screening boards, no-fault compensation). (4-6 hours)

5. Cooperation with Law Enforcement Agencies. Duty to report evidence of suspected crimes; gunshot and stabbing wounds; homicide and suicide; narcotics and dangerous drugs violations; sex offenses; neglected child statutes; rape; preservation of evidence. (1 hour)

6. Rights and Duties concerning Emergency Medical Care. In the emergency ward; good samaritan laws; consent; minors; responsibility; payment. (2 hours)

7. Hospital Regulations and Planning. J.C.A.H. Regulations; state licensing regulations; certificate of need; comprehensive health planning; Hill-Burton Program; tax-exempt status of hospitals and clinics. (2 hours)

8. National Health Insurance. Proposed federal legislation; Medicare; Medicaid; Blue Cross and Blue Shield; insurance systems in other countries; workmen's compensation. (2 hours)

9. Changes in Health Care Delivery. Health Maintenance Organizations (HMO's); Peer Review; Professional Standards Review Organizations (PSRO's); Certified Hospital Admissions Monitoring Program (CHAMP); Foundations for Medical Care (FMC). (2-4 hours)

10. Business Aspects of Medical Practice. Incorporation; partnership; taxes; pension plans. (2 hours)

11. Medical Decision-Making. Society's mandate to the medical profession; the importance of identifying the decision-maker and interests involved; who will decide and how; current models. (2 hours)

12. The Beginnings of Life. Amniocentesis; contraception; abortion; sterilization; genetic intervention and engineering; asexual reproduction; rights of the developmentally disabled; infant euthanasia. (2-4 hours)

13. Patients' Rights. The citizen as patient; the right to health care; informed consent; patient's rights in the doctor-patient relationship; the right to the truth; the right to choose one's treatment; the right to refuse treatment; nurses' rights; patient bills of rights; a patient's advocate system. (2-4 hours)

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14. The Law and Ethics of Transplantation. Resource allocation; alternatives; selection; consent; payment; autopsy procedures. (2 hours)

15. Behavior Modification. Psychosurgery; chemotherapy; psychotherapy; institutionalization; use of positive and negative reinforcement. (2 hours)

16. Experimentation. Informed consent; prisoners; children; mental incompetents; rights of the family to consent; new drugs and the F.D.A.; research review committees; surgical innovation; regulation of medical devices; rights of society. (2-3 hours)

17. Rights of the Dying Patient. Resource allocation; refusing treatment; consent; euthanasia; "living will"; psychotropic drugs; organ donation and autopsy. (2 hours)

18. Confidentiality and Privacy. Doctor-patient relationship computerization of hospital and office records; use of social security number as patient identifier; access to and ownership of records; use of patient for teaching purposes; doctor's right to practice medicine. (2 hours)

19. Creating Law. How to present scientific material to a legislative committee hearing; written and oral testimony before the legislature. (2 hours)

HOW SHOULD THE COURSE BE TAUGHT?

This question presupposes the answer to another related question, who should teach this course? The course should be taught by an academic attorney, preferably a member of a law school faculty. This is for two reasons: (1) there is less animosity between academic lawyers and doctors than between practicing lawyers and doctors; and (2) the course is not designed to be a "how to do it" course (e.g., how to preserve evidence, how to testify, how to avoid malpractice), but a "how to think" course. The reason that an attorney is to be preferred over a physician should be apparent from the preceding discussion. This is to be a course in law, not in how doctors get shafted by the law.

Since law professors usually teach groups of 90-130 students in a class, a large class would not be a problem. This model, utilizing the Socratic method, is also rather effective in drawing students into discussions--something which the medical student is generally unaccustomed to. In addition to transferring the basic law school case method-discussion technique to the medical school classroom, other approaches might

also prove effective. One is to have two attorneys debate various issues in front of the class, and follow the debate by a discussion. In one such class in which I participated, for example, the students (near the end of their first year) were asked to vote "yes" or "no" on two propositions: (1) Should the doctor follow the wishes of the parents of a five-year-old severely retarded, institutionalized hydrocephalic child, and passively end the child's life by not treating pneumonia? (2) Should society adopt a program of mandatory sterilization for women on welfare who have given birth to more than 4 retarded children? The students were asked to vote again on these two questions following the debate. Fully 40% of the class changed their votes on each question following the presentation. The point is not that first-year medical students are easily swayed, but that they had not thought through all of the issues. Not only does this approach expose them to a wide variety of issues in a short period of time, it also demonstrates first-hand the legal method of advocacy.

All this is not to say that small seminars of 12-20 students are not feasible. Indeed, I have taught small-group courses on "The Legal Rights of Hospital Patients," "Law and Genetics," and "Human Experimentation." These courses have consisted of students enrolled in law, nursing, medicine, and psychology. Perhaps in such a setting the mix of students is as important as the subject matter, because it exposes the medical student to a variety of ways of examining issues which confront the practicing physician. I have found the case method the most successful in the small interdisciplinary seminars. The problem is that the manpower requirement is tremendous if one is trying to reach all of the students. On the other hand, if what is desired is in-depth study in a speciality area for a few highly motivated students, the approach is ideal.

WHEN SHOULD IT BE TAUGHT?

Because it is difficult for the student to understand the relevance of law to medical practice until the student understands something of medical practice, it is probably acceptable to reserve this course until the fourth year of medical school. The difficulty at this point, of course, is scheduling. There are a couple of approaches. The course could meet in the evening for two hours a week for both semesters. Alternatively, the first month of the year could be set aside for 4-6 hours of lectures a day over a 3-4 week period. Other schedules may suit particular schools better. Another approach that has much to commend it is to have the attorney-teacher (one or more) at all basic lectures in the first and second year which involve serious medico-legal issues. Thus in cardiology the questions of disability, evaluation, definition of death, transplantation, consent, and legal causation could be discussed. In obstetrics and gynecology the legal issues concerning abortion, sterilization, contraception, and rape, and how these issues

relate to minors could be discussed, etc. While this approach may be "ideal," as a practical matter it would require both a full-time legal faculty member and close cooperation of all members of the medical school faculty.

It should be emphasized that after completing the above-outlined course, the student's training in legal medicine has only commenced, not concluded. More and more frequently hospitals are offering periodic grand rounds on legal issues, and this trend should be encouraged. It should also prove useful to add an attorney to some of the more routine grand rounds subjects to see what legal issues the lawyer can spot, and discuss how the medical community should resolve them.

Oliver Wendell Holmes once observed that "The life of the law is not logic, it is experience." This applies to any approach to teaching law in medical schools: experience will prove the best teacher, and a flexible approach toward achieving carefully thought out goals will prove the most successful.

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Editor's Note

A recent issue of Texas Reports on Biology and Medicine includes an article by Sam A. Banks that is a helpful supplement to the summarized report on the following pages. In an essay called "The Newcomers: Humanities and Social Sciences in Medical Education," Professor Banks discusses rationale, process, and context in relation to the incorporation of "newcomer" disciplines into health professional education. Please see Texas Reports on Biology and Medicine, Spring, 1974, 19-30.

The Spring issue of this journal, called "Humanities and Medicine," is devoted entirely to consideration of humanistic studies and their relation to medicine. It contains five categories of articles: The Humanities in Medicine; History and Medicine; Law and Medicine; Philosophy, Ethics, and Medicine; and Theology and Medicine.

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Group E: Social Psychology, Medical Behavioral Sciences, and Health Professional Education

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Summary of Group Discussions

Rationale: Why teach social psychology and the medical behavioral sciences as part of health professional education?

This group discussion began with acknowledgement of two different strains of methodology and content that have come together in the blend usually meant when one speaks of the social and behavioral sciences. On the one hand are the scientific and statistical methodologies of disciplines such as bio-engineering, and on the other hand is the focus on behavior of disciplines such as sociology.

Seeking to identify the range of disciplines subsumed under the rubric "social and behavioral sciences," this group listed psychology, sociology, social psychology, anthropology, political science, political economy--and possibly history as a discipline that is a unique bridge between the humanities and the social and behavioral sciences.

Despite some misunderstandings about the nature of the social and behavioral sciences, they do have content--a body of knowledge applicable to many areas of human life, including health and illness and medical care. The members of this group felt that their respective disciplines can contribute to health professional education by offering content that is not now part of most curricula for training health professionals. For example:

1. The effect of interpersonal relationships on patient care.

   More is involved here than practitioner/patient relationships. The quality and delivery of health care are affected also by relationships between physician/nurse, nurse/technician, administration/professional staff, etc. Setting is also a factor. Urban ghettoes and rural isolation affect the provider of health care as well as its recipient.

2. The nature, meaning, and consequences for medical care of concepts of class (e.g., blue collar, elite) and role (e.g., sex-specific, age-determined).

3. The process and meaning of professionalization.

   Strong sanctions of many kinds go along with professional life. This affects how patients relate to professionals, how professionals relate to each other, etc.

4. The process and meaning of socialization.

   How do people get to be the kind of persons they are? How do they become <u>social</u> persons as well as private personalities, and how do the personalities they develop influence interaction with others?

5. The components of social interaction: attitudes, values, behavior, etc.

6. The nature and use of evaluation and measurement techniques.

   It <u>is</u> possible to assess the relative success of various kinds of treatment, health-care delivery systems, institutional staffing patterns, and a host of other variables that impinge upon the health professional's performance of his/her job.

7. The structure and function of organizations/institutions.

   Personal, professional, and institutional goals need not be in conflict. Social scientists have studied organizations and organizational relationships for a long time, and have developed a large body of knowledge that has practical application to the various settings and environments in which health professionals work.

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Another kind of contribution that was discussed lengthily and enthusiastically had to do with fostering breadth of conceptual framework. Noting that the health professions are studied largely through reading (especially during postgraduate and continuing education), some participants in this discussion emphasized that reading facts is not enough: they must be interpreted in order to reach their larger meaning. The humanistically-trained mind can engage in this kind of abstraction and conceptualization, and remain alert to the need to question and challenge assumptions.

Over its long history, medicine has acquired a dangerous familiarity with a large number of unexamined assumptions. Among examples discussed by the group was, "Ultimate responsibility rests with the physician." Does it? Why? Why not with the patient himself? Why not with his family?

Is it also true that "most symptoms have a physiological basis"? That "most of a physician's time is spent making people well"? Who is available and who has appropriate skills for helping health professionals examine these and other "cultural" assumptions and values? Many humanists believe that they can offer this kind of assistance, in addition to the contributions through teaching listed above.

Process: How can this kind of teaching be accomplished successfully?

Rather early in the discussion of this question, the focus shifted from the teaching of social and behavioral science to the teaching of values. There was quick agreement that the inculcation of any particular set of values is not desirable, but awareness of one's own and others' values is very desirable. If values-teaching is successful, it leaves students free to make informed, examined choices about whether or not to retain, abandon, or alter their values. It also equips them to respect other persons' values, and to recognize situations that will trigger interplay of everybody's values.

Because so much of health professional education occurs in medical centers, students come under the influence of institutional values as well as the individual values of their "role models": their teachers, clinical preceptors, and other significant figures. Unfortunately the institution often encourages and rewards the wrong priorities, especially in its tendency to prize efficiency and productivity.

Left to their own inclinations (especially at the beginning of their training), students prefer human interactions to mechanical transactions,

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and they are confused and threatened by the conflict they perceive between their own values and those of the institution. It takes quite some time for them to dare to decide (and then act accordingly) that in some instances, at least, their own values are better than those of the model put before them.

Since many aspects of the student experience are dehumanizing to the students themselves, it should not be surprising that ultimately many of them give dehumanizing health care. They are taught within a system that pays lip-service to cooperation (e.g., the health care "team"), but at all levels rewards competition ("most" patients seen daily, "quickest" diagnoses, "longest" bibliography, etc.) Nurtured in such a system, students do not learn to regard health care and subsequent health maintenance as a cooperative, shared enterprise in which practitioner and patient can meet humanly.

Context: What milieu is most conducive to the continuing development of the social and behavioral sciences as part of health professional education?

The group seemed to value the fact that at this time, there is no acknowledged model for incorporating the social and behavioral sciences into health professional education. This allows freedom to adapt to a variety of teaching-learning situations, without the encumbrance of baggage from the past.

Early in the discussion ~~of a place~~ for the social and behavioral sciences in a given institution, there might be consideration of a unique function they can perform for the parent institution. It is one that contains the possibility of benefit to everyone: study of the institution itself through research focused on its own structure and activities. On-going examination of the institution can provide simultaneous opportunities for teaching/learning, research/evaluation, health care/clinical investigation.

In creating a place for the social and behavioral sciences, it is well to recognize at the outset the existence of certain realities that necessarily limit any new undertaking, especially if it is on an institutional scale. Power structures are one example, and limitation of all kinds of resources is another. Fashioning a teaching-research situation is as much a political and administrative activity as it is an academic and clinical matter. Therefore program founders should involve appropriate representatives of "the system" in the planning and subsequent activity of their programs to the greatest extent possible.

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ON HUMAN VALUES IN MEDICINE

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Galveston, Texas
October 18 - 19, 1973

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EVALUATION OF THE SOUTHWEST REGIONAL INSTITUTE ON HUMAN VALUES IN MEDICINE

Holiday Inn, Galveston, Texas
October 18-19, 1973

This evaluation will be helpful in preparing subsequent programs dealing with human values in medicine. Your candid responses are requested.

1. Did you find this regional institute helpful to you as a person? If yes, how? If not, why not?

2. Did you find this regional institute helpful to you in thinking seriously about teaching programs that relate the humanities to the health professions? If yes, how? If not, why not?

3. Identify one feature that you liked very much about this institute:

4. Identify one characteristic that you disliked very much about this institute:

5. In terms of their relative value to you in thinking about academic programs dealing with human values in medicine, assess the following:

   A. Whole group assemblies (Dr. Banks, Summaries, Dr. Burns):

   B. Small Group - Session #1 (What should be taught?):

   C. Small Group - Session #2 (Why should it be taught?):

   D. Small Group - Session #3 (How should it be taught?):

   E. Quintets:

6. Would you have changed the format of the institute? If so, how?

7. Were you satisfied with the consultants? If not, why not? Be specific.

8. As an introduction to relationships between humanities and the health professions, this institute was _____ very helpful _____ moderately helpful _____ not helpful. Briefly account for your answer.

9. As an occasion for exploring in depth crucial issues involving academic relationships between the humanities and the health professions, this institute was _____ very helpful _____ moderately helpful _____ not helpful. Briefly account for your answer.

10. Prior to our workshop, you should have received copies of the Proceedings of the first and second sessions of the Institute on Human Values in Medicine. Did you read them? ____ Yes ____ No
If you read them, were they helpful to you in preparing for this regional institute?

11. Any additional comments you might wish to make will be appreciated.

_____
Please Print Name and Address

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